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# ESSENTIALS OF CORRECTIONAL NURSING

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# Essentials of Correctional Nursing

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*Lorry Schoenly, PhD, RN, CCHP-RN*  
*Catherine M. Knox, MN, RN, CCHP-RN*

**Editors**

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## Preface

*Essentials of Correctional Nursing* reviews the body of knowledge and practice standards that define the specialty of correctional nursing. The text also describes the health care needs of the youth, men, and women who are incarcerated in jails, prisons, and detention centers across the country. This is a population that is disenfranchised from society, often stigmatized, and invisible to the general community.

The intent of this book is to support correctional nurses by providing guidance and resources about the best practices to deliver nursing care that reduces suffering and improves the quality of life for incarcerated individuals, their families, and the community at large. Nurses who work in other settings also encounter patients who are incarcerated or who have been incarcerated. These settings include emergency departments, specialty clinics, hospitals, psychiatric treatment units, community health clinics, substance abuse treatment programs, and long-term care settings. Explanations and resources are provided in the book so that nurses in other settings are comfortable assessing and responding to the health needs of these patients. Students in graduate and undergraduate nursing programs may use the text to prepare for a learning experience in the correctional setting or to understand health care needs of this population in relation to community health.

Correctional nursing practice is complex. Nearly 1 of every 100 people in the United States is incarcerated in a jail, prison, or juvenile detention facility. Health needs of this population are characterized by disproportionate rates of mental illness, alcohol and drug dependence, victimization, traumatic injury, and both chronic and infectious disease. Minorities are overrepresented among the incarcerated, so correctional nurses are vigilant in the identification and treatment of conditions that represent greater morbidity and mortality for these groups and deliver care with cultural competence. Chapters are devoted to the nursing care provided to patients who have chronic disease, infectious disease, mental illness, or pain, or who are in withdrawal. Other chapters describe the unique health needs and resulting nursing care for specific populations, including women, juveniles, or individuals at the end of life.

The setting for delivery of nursing care is challenging. Correctional facilities operate to carry out criminal sanctions imposed by the court, not to deliver health care. Yet correctional facilities are obligated by state and federal law to provide health care to prisoners and other detainees. The operation of correctional settings and the legal obligation for care can create ethical challenges for nurses dealing

with such issues as patient privacy and self-determination. The setting also challenges a central tenet of nursing, the concept of caring. *Essentials of Correctional Nursing* describes how nurses safely navigate the correctional environment to create a therapeutic alliance to center their nursing care on the patient.

Nurses have been described as the backbone of correctional health care. They are the eyes, ears, hands, heads, and hearts that respond to medical and mental health emergencies. During daily sick call and other routine health care encounters, correctional nurses listen to patients' health concerns and watchfully encourage other individuals who are unable or unwilling to raise a health concern. Nurses must apply their knowledge, skill, and ability to the assessment and diagnosis of the full range of health conditions presented by this population and determine both the urgency and priority of subsequent care. Nurses are often the primary gatekeeper to other health care professionals in the correctional setting. Chapters devoted to health screening, medical emergencies, sick call, and dental care describe how nurses identify, respond to, and manage these health concerns in the correctional setting.

The American Nurses Association (ANA) recognized correctional nursing as a specialty within professional nursing in 1985 with the publication of *Corrections Nursing: Scope and Standards of Practice*. The ANA standards are interwoven into each chapter of *Essentials of Correctional Nursing* and are used by correctional nurses to guide nursing practice with resulting improvements in patient care.

Improvements in the delivery of care have been achieved by the establishment of standards and accreditation offered by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC). Both the ACA and NCCHC offer certification exams for nurses to demonstrate their expertise in correctional health care. *Essentials of Correctional Nursing* was written to provide the content and structure to support nurses in studying for these certification examinations.

Correctional nurses participate in all of the interdisciplinary organizations, including the American Correctional Health Services Association, the NCCHC, the ACA, and the Academy of Correctional Health Professionals, often serving in leadership positions on boards and committees. *Essentials of Correctional Nursing* was written and reviewed by experienced correctional nurses who have devoted thousands of hours to the work of these organizations.

There is much to be done in correctional nursing to develop the evidence on which best practice is based. Correctional nurses need to further define and develop this area of professional practice, to transform health care delivery to improve patient outcomes in correctional settings, and to advocate on behalf of individual patients as well as the population for adequate health care. *Essentials of Correctional Nursing* provides a framework for review and application of research to promote quality patient care. Finally, nurses are invited to reflect on their own practice and challenged to consider the future of correctional nursing, setting the stage for growth of the specialty.

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Readers are invited to visit Dr. Lorry Schoenly's blog that explores essential skills and competencies in correctional nursing at <http://essentialsofcorrectionalnursing.com>.

## I: OVERVIEW OF CORRECTIONAL NURSING

### ONE

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## Context of Correctional Nursing

*Lorry Schoenly*

Correctional nursing is “. . . the practice of nursing and the delivery of patient care within the unique and distinctive environment of the criminal justice system . . .” (ANA, 2007, p. 1). This criminal justice system includes county jails, state and federal prisons, juvenile detention centers, and substance-abuse treatment centers.

Correctional nurses practice in a specialized environment, one that does not embrace health care as its primary mission. The patient population, inmates and detainees, is unique as well. Although professional nursing practice is based on universal concepts, the application of these care concepts in this specialized environment to this unique patient population provides the primary components of the nursing specialty. An understanding of the care environment, patient population demographics, and the culture of correctional professionals helps to frame the practice of a correctional nurse and informs the care provided.

There are both rewards and challenges to the practice of correctional nursing. Initial investigation of the correctional nursing role indicates that nurse responsibilities can vary greatly depending on the size and type of facility. The role can provide increased autonomy of practice and potential for reduced conflict with other health care professionals (Flanigan & Flanigan, 2001; Shelton, 2009; Smith, 2005). The majority of jail nurses responding to a survey described the reaction of their peers when the nurse said that they provided health care to offenders as most often consisting of respect, interest, and fascination (Hardesty, Champion, & Champion, 2007). These researchers also found that socialization to the role of correctional nurses (such as a rotation during school or having a member of the family who works in a correctional facility) and prior work experience in emergency or mental health environments contributed to jail nurse job satisfaction. The variety of daily activities

**TABLE 1.1 Daily Functions of Correctional Health Care Nurses**

FUNCTION	PERFORMED DAILY
Patient education	70%
Physical exams	55%
Medication distribution	52%
First aid	49%
Counseling	41%
Health screening	38%
Staff education	22%
Postoperative care	4%
Drawing blood	3%
Detoxification	1%

Source: Adapted from Flanigan and Flanigan (2001).

and potential for novel situations can also be attractive. Table 1.1 describes the types of activities in which the nurses responding to this survey were engaged and how often they performed each activity.

Correctional nursing practice is a challenging nursing specialty for several reasons. Health care units in jails and prisons are often underequipped and do not have appropriate space for delivery of health care. The location of the health care unit may have been an afterthought in facilities that were built before the advent of organized onsite health care. Some correctional facilities were built in isolated, rural locations, making it difficult to recruit health care professionals. Professional isolation can be a problem in retaining nurses once recruited. Many correctional facilities are overcrowded, leaving little room for privacy in dealing with health care concerns. Privacy issues are also increased by the need for correctional officer oversight of the health care delivery areas in order to maintain safety of staff and other inmates. Some inmates must be isolated in higher security units with restricted movement, making it necessary to deliver health care in the housing area.

The implications of a caring relationship between the correctional nurse and the inmate-patient also create a challenge to practice. Correctional nurses must establish a therapeutic relationship with individuals convicted of crimes, some of a violent nature. Reconciling the humanity of the patient in need of health care with the criminal behavior of the inmate is an important aspect of providing care. Correctional patients have been described as “difficult, manipulative, aggressive, and demanding” (Flanigan & Flanigan, 2001, p. 75). A significant number of inmate-patients seek health care services for secondary gain such as additional privileges, reduced work assignments, or special clothing (Paris, 2006). This can cloud the nurse’s evaluation and treatment decisions. The increased autonomy of the correctional nurse and the need to sort out desire for secondary gain from true medical need requires solid assessment and critical thinking skills. Finally, creative patient education plans are required due to limited healthy living options such as fresh fruits and vegetables or adequate exercise.

Negotiating with other entities in the care environment also brings challenge. Strict boundaries set by the corrections system can prove frustrating to nurses

desiring to show compassion for patients (Weiskopf, 2005). In the custody environment, nurses may feel that they are forbidden from entering into a caring relationship with an inmate-patient (Maevé, 1997; Maroney, 2005). The noncaring attitudes of others in the work environment such as security officers, other staff members, and the inmate population can influence nursing attitudes over time (Weiskopf, 2005). Some correctional nurses must balance the conflicting roles of being employed by an organization with a mission of public safety and security while upholding a professional mission of health and well-being for the inmate population (ANA, 2007).

Finally, the need to be ever-vigilant about personal security in a potentially unsafe environment can erode the caring relationship with patients. Unlike many other care environments, nurses must await an evaluation of the safety of an environment before entering to assist in emergency treatment. The continual concern for personal safety while delivering care can challenge basic principles of caring. Therefore, it has been said that correctional nurses “walk a tightrope between providing therapeutic treatment and maintaining a secure environment” (Weiskopf, 2005, p. 341).

### **EXHIBIT 1.1** **Principles of Correctional Nursing**

- A registered nurse’s primary duty in the corrections setting is to restore and maintain the health of patients in a spirit of compassion, concern, and professionalism.
- Each patient, regardless of circumstances, possesses intrinsic value and should be treated with dignity and respect. Each encounter with patients and families should portray professionalism, compassion, and concern. Each patient should receive quality care that is cost effective and consistent with the latest treatment parameters and clinical guidelines.
- Patient confidentiality and privacy should be preserved. Nurses should collaborate with other health care team members, correctional staff, and community colleagues to meet the holistic needs of patients, which include physical, psychosocial, and spiritual aspects of care.
- Nurses should encourage each individual through patient and family education to take responsibility for disease prevention and health promotion. Each nurse maintains responsibility for monitoring and evaluating nursing practice necessary for continuous quality improvement.
- Nursing leadership should promote the highest quality of patient care through application of fair and equitable policies and procedures in collaboration with other health care services team members and corrections staff.
- Nursing services should be guided by nurse administrators who foster professional and personal development. These responsible leaders are sensitive to employee needs; give support, praise, and recognition; and encourage continuing education, participation in professional organizations, and generation of knowledge through research.

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Correctional nurses maintain the professional nature of their practice through a principled approach to patient care. These ANA-affirmed principles focus correctional nursing practice on the health and safety needs of the patient population while providing a compass to navigate the correctional system for themselves as well as their patients. The essence of correctional nursing is caring for and respecting the human dignity of the incarcerated (ANA, 2007). Limited resources, challenging patients, competing security priorities, and ongoing concern for personal safety can mitigate against principled nursing practice. A frequent return to the core values and goals undergirding correctional nursing practice helps re-center nurses on the meaning and importance of their role (Exhibit 1.1).

## HISTORY OF CORRECTIONAL NURSING

Although health care has been delivered in the U.S. correctional environment as early as 1797 with the opening of Newgate Prison in New York City (ANA, 2007), the establishment of the correctional nursing specialty came much later. The correctional setting for nursing practice began to emerge in the professional literature in the 1970s as nurses became involved in developing working systems of health care in this setting (Murtha, 1975). Prison riots, the civil rights movement, and civil litigation shed light on the invisible prison health care setting. In addition, health care for the incarcerated received a legal mandate with the 1976 Supreme Court decision of *Estelle v Gamble*. This case established the constitutional obligation to provide health care to any citizen in the custody of the government.

While still in its infancy in comparison to more mature nursing specialties, correctional nursing has been recognized by the American Nurses Association (ANA) since 1985, when the Task Force on Standards of Nursing Practice in Correctional Facilities under the direction of the Executive Committee of the Council of Community Health Nurses published *Standards of Nursing Practice in Correctional Facilities* (C. Bickford, personal communication, July 1, 2011). Professional development of the specialty has included certification through at least two multidisciplinary groups (American Corrections Association, National Commission on Correctional Health Care). Most nurses who have worked in traditional settings such as a hospital or clinic before entering corrections find the specialty to be unique. Others have described it as similar to nursing care delivered in a psychiatric, military, or public health clinic setting (Flanigan & Flanigan, 2001).

Nurses are the predominant health care providers in the correctional setting. They are often the first to see a patient in need of service as well as the ones to assure that appropriate treatment is received. The limited and fragmented nature of health services in corrections requires solid care delivery processes and reliable follow-through. Nurses are often the managers of care delivery processes in this setting. Establishing efficient and effective care delivery in the midst of the conditions cited makes this specialty both challenging and rewarding.

## CARE DELIVERY ENVIRONMENT

Over 7.2 million people are under some form of correctional supervision in the United States (Glaze, 2010). The size and type of correctional facility and the level of security can affect the types of health care services delivered and therefore the provision of

nursing care. Generally, nursing care is not delivered in parole and probation settings. Individuals complete these supervised experiences in the community and have access to community or public health service resources. Correctional nursing takes place in jails, prisons, and juvenile detention settings.

### **Correctional Nursing in Jails**

Local jails are managed by counties or cities and hold individuals awaiting court hearings, trials, or sentencing. In addition, individuals may remain in the jail setting to serve out sentences of 12 months or less rather than be processed and classified into a state or federal prison system (Minton, 2011). The temporary and transient nature of a jail stay lends an emergent nature to the health care delivered; however, chronic conditions must still be considered and treated. Drug and alcohol withdrawal is a frequent issue and patients with mental health conditions may not be currently taking their medications. Stabilizing the health condition of newly entering inmates is a priority.

Rapid turnover can result in incomplete treatments, missed diagnoses, and uncontained communicable diseases. It is important for nurses working in a jail setting to have strong links with local community and public health services to extend treatment past the facility walls.

### **Correctional Nursing in Prisons**

Prisons house individuals who have been convicted of a crime with sentences generally longer than 12 months. The extended nature of the stay leads to health management of a more long-standing nature that can include managing chronic conditions and surgical procedures. There are two systems managing prisons based on sentencing. The Federal Bureau of Prisons (FBOP) manages a prison system of 102 facilities housing inmates serving sentences related to a federal crime (Bureau of Justice, 2008). These facilities are spread throughout the United States but have centralized management and similar standards of practice.

By contrast, state prison systems are under the jurisdiction of the state's government and practice standards are consistent throughout the network of state facilities but may differ among the states. Several states (Delaware, Rhode Island, Massachusetts) have combined jail and prison facilities, where both detainees and sentenced inmates reside.

### **Correctional Security Levels**

Inmates are brought into a prison system from jail custody after sentencing. State and federal prison systems designate intake facilities where incoming inmates are evaluated and classified on a number of factors that lead to a facility assignment. Intake facilities are arranged to rapidly evaluate an individual's psychological, criminological, and medical status for placement. Nurses working in a prison intake facility develop excellent assessment skills.

Although terminology can vary from state to state, prisons are categorized by the degree of security needed to maintain the safety of inmates, staff, and the public. Security level designates the degree of external and internal environmental controls in place, as well as the security staff to inmate ratio. Higher levels of security require lower ratios and greater environmental controls.

The security level of a prison will determine the degree of restriction, particularly on the movement of inmates to and from the medical area and the level of

custody involvement in the medical unit. Some large prison complexes may have a mix of security levels among buildings within a common external perimeter. It is important to know the security level of a facility, as this indicates characteristics of the patient and the nursing care environment.

#### *Minimum Security*

Minimum or low security facilities house inmates designated as low risk for violence or elopement (FBOP, n.d.). Minimum security facilities focus on personal responsibility and inmates may be involved in community work assignments. Minimum security facilities may also include working farms, machine shops, and military-style boot camps (North Carolina Department of Corrections, n.d.).

Health care may only be available part of the time. Nurses working in these facilities are involved in medical clearance for work programs. In addition, care activities can include evaluation and treatment of work-related injuries.

#### *Medium Security*

Inmates designated for a medium security setting have been determined to be an escape risk and pose a threat to others (Executive Office of Public Safety and Security, n.d.). Inmates in these facilities have more direct supervision and more restricted movement. Medium security settings have more work and self-improvement projects within the external security perimeter and fewer patient transports or contact with the public.

Health Units in medium security prisons are usually staffed 24 hours a day and involve a full array of ambulatory services. They are more likely to include infirmary care and initiate treatments such as IV therapy and tube feedings as needed. Health care is delivered primarily in the health care unit, although nursing staff must be able to deal with emergencies (man-down) in the housing and exercise areas. Permanent security staffs are often assigned to the health care units in medium security settings and inmate-patients are observed at all times.

#### *High Security (Maximum)*

Inmates designated for high security settings have been determined to be a serious escape or violence risk. High security prisons have a variety of descriptors including penitentiary, maximum, super max, and close security. Death row inmates and those convicted of particularly violent or heinous crimes will be assigned to high security prisons. The internal environment of high security settings includes a greater degree of physical barriers and checkpoints.

Nurses working in maximum security prisons must deliver a greater percentage of care cell-side due to the security nature of the setting. Inmate movement is limited and security staff escorts are required for movement to the health care unit. Sentences are typically long in maximum security prisons and so the health care trajectory can also be longer than in other settings. A full array of health care services is provided including ambulatory care, infirmary care, and chronic disease management.

#### **Special Housing**

Correctional facilities also have special housing areas for increased security purposes or for vulnerable inmate populations. Correctional nurses may have responsibilities for providing nursing care in these specialized environments. Terminology may

differ across systems and within various regions of the country. It is important, therefore, to understand the meaning of the various special housing situations within the system or facility of employment.

### *Segregation*

This specialized unit, also called Seg, Administrative Seg, Protective Housing, or Secure Housing Unit (SHU), is a restricted security area within a jail or prison for inmates who continue to violate security rules, threaten, or otherwise place other inmates and staff members in danger. Inmates placed in segregation have their movement severely restricted. Health care must be provided in the housing area with an escort by correction officers. Delivery of medication and treatments can be challenging and if appropriate facilities and equipment are not available, nurses may be expected to deliver such care cell-side. Nurses must be prepared for the possibility of verbal abuse or attempts at physical disruption such as spitting or throwing of bodily excrement. Patient privacy during examination and history-taking can be difficult. Special arrangements and additional security are required when segregated inmates are transported to the medical unit for evaluation or treatment.

### *Medical, Sheltered, or Protective Housing*

Medical, sheltered, and protective housing units are created in large correctional institutions or systems to provide added safety for inmates with physical or mental impairment that could lead to victimization in the general inmate population. The older inmate, adolescents sentenced as adults, and those with significant disability require extra protection, as do those with severe mental health issues such as schizophrenia or psychoses. Medical, sheltered, and protective housing units are often located near the health care unit.

### *Prerelease*

Prerelease facilities and half-way houses are used to prepare inmates nearing the end of incarceration by developing independent skills for community living. Prerelease facilities generally have minimal health care staff and frequently refer inmates with chronic or serious acute conditions to a nearby higher-level prison medical unit for treatment.

## **CORRECTIONAL MANAGEMENT STRUCTURE AND HEALTH CARE DELIVERY**

Correctional health care units can be managed in several ways. Unlike hospitals or clinics in the community, the health care staff in a correctional setting may not report directly to the same leadership as other staff in the facility (Table 1.2). Having an understanding of lines of authority within the facility can improve effectiveness and decrease message confusion.

### **Governmental Agencies (Self-Operated)**

The majority of nurses working in corrections are employed by the same governing body as their custody peers. Also called self-operated or self-op, health care managers in this management structure are a part of the organizational hierarchy and reporting framework. This organizational framework has advantages in allowing for parity

**TABLE 1.2 Management Systems for Correctional Health Care Units**

MANAGEMENT TYPE	PORTION OF THE U.S. CORRECTIONAL SYSTEM
Government agencies (self-operated)	58%
Independent health care service companies	30%
State university medical systems	12%

Source: Adapted from Corizon (2011).

among the services and can foster support for inmate medical needs. Although the wellbeing of the inmate population is a common goal for both custody and nursing staff, professional frameworks and guiding principles can differ. Nurses in these organizations must be vigilant to maintain professional nursing judgment in all matters of care delivery.

### Independent Health Care Service Companies

Another way correctional health care is provided through contracts with independent health care service companies. These companies contract with county or state governments to deliver needed health care services within correctional facilities. Nurses are most often employees of the health care service company and report to managers within the company. When working for a company independent of the correctional authority, nurses must understand the contractual relationship with the Department of Corrections and the communication and reporting structure. Health care staff in this situation are guests in the facility and must strive to develop collaborative working relationships with custody staff.

### State University Medical Systems

Several state prison systems provide health care to inmates through the state university system. For example, in Connecticut, inmates receive care through the University of Connecticut medical system, and in New Jersey, health care services are provided through the state's University of Medicine and Dentistry. Nurses working in these systems have the advantage of access to academic resources while nursing, medical, and dentistry students have an opportunity to experience the correctional environment. The corollary in jails is for the county health department to provide the health care at the jail. In this circumstance, nurses have the advantage of access to resources of the county health department. Although health care staff are not employees of the same entity as corrections staff, a common relationship exists among the government bodies.

## CORRECTIONAL OFFICER DEMOGRAPHICS

The environment in which correctional nurses provide patient care is shaped by the professionals managing the primary service of security within the facility. Correctional officers, also called CO's, custody officers, or security officers, are professionals with their own perspective and worldview gained during training for their role and

assimilation into their work environment. Primary concerns of correctional officers are order, control, and discipline (Maroney, 2005). These themes provide a framework for the systems and processes that help manage the corrections environment.

The work environment shapes the actions and reactions of correctional officers. High levels of work stress, ongoing potential for workplace violence, and a perceived lack of public support can create bonds of solidarity among the custody staff (Garcia, 2008). Correctional nurses must somehow bridge this solidarity without compromising nursing professional principles when collaborating with custody staff to accomplish care goals.

### *From the Experts . . .*

“Mutual respect will go a long way to facilitate collaboration with security staff. Correctional officers and administrators have a hard job. Correctional nurses need to recognize this and refrain from being overly critical or judgmental about security perspectives about prisoners—without sacrificing their nursing perspective. Simply put—the words “please” and “thank you,” professional courtesy, and consideration will help nurses collaborate with their security colleagues.”

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## **PATIENT POPULATION DEMOGRAPHICS**

Individuals detained or in the custody of the corrections system have several terms used as identifiers. Individuals held in pretrial settings such as county jails can be called detainees or arrestees. Once sentenced, the most common terminology is offender or inmate. For the purposes of this discussion, the terms inmate or patient will be used to designate the patient population receiving correctional nursing care.

The U.S. inmate population has grown considerably over the last three decades for a variety of reasons. In fact, the United States has the largest incarcerated population in the world, at 2.3 million inmates. The second largest inmate population, China, is far behind with 1.5 million. Russia is a distant third with less than a million behind bars. Reasons given for the higher incarceration rate include tougher sentencing rules, three-strikes measures, and reduction of mental health hospitalization options (The PEW Center on the States, 2008; Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010).

Slightly more than one in every 100 Americans is behind bars (Pew, 2008). The incarcerated population does not mirror general population statistics as to gender, race, education, or age. The contrast helps to frame the type of necessary health care services provided by correctional nurses.

### **Gender**

The majority of incarcerated Americans are male adults. The Bureau of Justice Statistics for 2009 indicates male individuals are imprisoned at a rate 14 times the rate for female individuals. Local jail detainee populations are, on average, almost 88%



male (Glaze, 2010). Male inmates are more likely than female to be alcohol dependent (Binswanger et al., 2010). Although women make up only 10% of those incarcerated, their numbers are increasing nearly twice as fast as men (Pew, 2008). Stricter sentencing laws bring in a greater number of female individuals who were part of a domestic violence disturbance or an accomplice to a male-directed criminal activity such as driving a boyfriend or spouse to a theft or drug deal (Kelly, Parlaz-Dieckmann, Chang, & Collins, 2010).

Female inmates are more likely than their male counterparts to have custody of their children and to have been a victim of sexual abuse or domestic violence (Belknap, 2006; Kelly et al., 2010). The health issues of incarcerated women expand to also include reproductive health issues. In addition, women have a disproportionately higher rate of treated mental illness (Binswanger et al., 2010) with increased prescription of psychotropics and tranquilizers (Belknap, 2006). Those providing health care in female institutions find a higher use of medical and psychiatric services than similarly sized male institutions (Binswanger et al., 2010; Drapalski, Youman, Stuewig, & Tangney, 2009).

### **Race**

African Americans and Hispanics are disproportionately represented in the U.S. inmate population. Although Black Americans make up 12.6% of the general population, they make up 39.3% of the incarcerated population (West, Sabol, & Greenman, 2010). While one in 106 White men over age 18 are imprisoned in America, one in 15 Black men in this age group are behind bars (Pew, 2008). Likewise, one in 36 Hispanic men aged 18 or older are incarcerated. Hispanic/Latinos make up 15.8% of the jail population (Minton, 2011) and 21% of the prison population (West et al., 2010).

Disproportionately higher numbers of minority inmates will impact the frequency of certain medical conditions treated in correctional settings. Not only are Black Americans three times more likely to have diabetes and stroke, but they are 11 times more likely to die of HIV disease. Black men have higher rates of prostate, lung, stomach, and colorectal cancers. Black women are more prone to prenatal diseases and cancers of the colon, pancreas, and stomach (CDC, 2005).

Health disparities in the Latino community also impact the inmate population. Hispanics have a disproportionately higher disease profile with increased death from stroke, chronic liver disease, diabetes, and HIV disease. Also, this population segment has a much higher rate of cancers of the stomach and cervix than the general population (CDC, 2004).

### **Education**

Education levels of the U.S. inmate population are lower than the general population. Harlow (2003) reports less than 50% of the total incarcerated population have a high school diploma. This figure is under 20% for the general U.S. population. Inmates are more than twice as likely as other citizens to have learning disabilities (Greenberg, Dunleavy, & Kutner, 2007a).

Literacy, a component of education level, that is of particular importance for health education, is also below normal levels in the inmate population. Using a three-factor scale of literacy evaluation (prose, document, quantitative), researchers found inmates, on average, were more likely to have only basic levels of literacy and below compared to the general population. In addition, very few prisoners were able to read and comprehend at the highest level (Greenberg, Dunleavy, Kutner, & White, 2007b).

Basic literacy allows interpretation of simple instruction and graphic material. Special consideration should be given to the reading level of printed health information provided to the inmate population. In addition, correctional nurses need to evaluate the patient's understanding of health information provided. Case Example 1.1 provides an opportunity to apply this information.

### **CASE EXAMPLE 1.1**

Nurses at a large maximum security prison are teaching patients about sexually transmitted diseases. While the inmates await their chronic care appointment in the clinic holding area, they are given written material from the Centers for Disease Control website. During the nurse portion of the chronic care visit, each inmate is asked if they received the material and if they have any questions. If they have no questions, the nurse documents successful patient teaching on the topic in the medical record. Describe flaws in this process and suggest improvements in the teaching method.

#### **Age**

Generally speaking, the majority of inmates in adult facilities are young male individuals. For example, the average inmate age in the federal prison system is 39 years (Bureau of Prisons, 2011). Inmates aged 20 to 39 make up 64% of the 1.45 million sentenced prisoners at the end of 2009 (Bureau of Justice, 2011a). The growing edges of the age continuum, youth and elderly, have specific health needs to consider.

#### *Elderly*

By all accounts, the U.S. inmate population is aging along with the general population as baby boomers move into retirement and geriatric care. However, due to many factors, inmates age earlier in life and elder inmates are growing in number behind bars due to maximum sentencing formulas developed in prior decades (Aday, 2003). Although the definition of elderly differs across systems, there is general agreement that inmates in their 50s are considered to be in this category (Anno, Graham, Lawrence, & Shansky, 2004; Loeb & AbuDagga, 2006). Elderly inmates use more medical and mental health resources. They require additional protection from abuse and predation. They often need protective housing and assistive devices. Both correctional officers and nurses must be vigilant to identify decreasing functionality and increasing disease burden in this segment of the inmate population (Anno et al., 2004).

#### *Youth*

The youth or juvenile designation is generally given to those under 18 years of age in the U.S. prison system. The majority of youth are detained and serve sentences in residential-styled facilities with an environment created to meet the needs of adolescents. Correctional nurses working in juvenile facilities deal with growth and development issues, psychosocial concerns, and parental custody matters.

A growing number of youth are given adult sentences and sent to adult facilities to serve out their time. Upwards of 25% of juvenile offenders are in adult prisons. Young inmates in adult prisons have increased rates of suicide and prison rape (Campaign for Youth Justice, 2007). Young offenders are a vulnerable population that



should have additional protections from the general prison population. It is important for correctional nurses in adult facilities to know about and monitor the youth segment of the inmate population. Youth nutritional needs and medical conditions are unique to their season of life and should be considered at every health care encounter.

## PHYSICAL HEALTH

### Chronic Illness

When age is standardized with the U.S. general population, inmates in jails and prisons were found to have higher rates of diabetes, hypertension, prior myocardial infarction, and persistent asthma (Wilper et al., 2009). Details of this difference are found in Table 1.3. Correctional nurses have an opportunity to improve inmate health and thereby public health through the evaluation and treatment of these chronic conditions during incarceration.

### Infectious Diseases

Poor nutrition, substance abuse, homelessness, lack of medical care, and risky sexual behaviors lead to a disproportionately higher rates of HIV, Hepatitis C (HCV), sexually transmitted infections (STIs), and tuberculosis (TB; Hammitt, 2006). Rates of HIV in federal and state prisons are nearly four times the general population, while up to 35% of inmates have chronic HCV infection (Gough et al., 2010). Tuberculosis in the corrections population is a growing concern, with reported rates at least 3 times that of the general population (MacNeil, Lobato, & Moore, 2005). STIs are also common in this patient group. Syphilis, chlamydia, and gonorrhea rates among jail and prison inmates are surprisingly high compared to the general population (Table 1.4).

Awareness of the increased likelihood of any particular patient to have one or more of these conditions can lead to early identification and treatment. Correctional nurses can help limit the spread of these diseases through patient education and encouragement of risk-reduction practices.

## MENTAL HEALTH

Mental illness among the inmate population is also more frequent than in the general population (Table 1.5). While 11% of Americans meet criteria for a mental health disorder, more than half of the jail and prison population have recent history or

**TABLE 1.3 Age-Standardized Prevalence of Selected Chronic Conditions Among Adult Federal and State Prisoners, Jail Inmates, and the Noninstitutionalized U.S. Population**

CONDITION	FEDERAL (%)	STATE (%)	JAIL (%)	GENERAL POPULATION (%)
Diabetes	11.1	10.1	8.1	6.5
Hypertension	29.5	30.8	27.9	25.6
Prior myocardial infarction	4.5	5.7	2.1	3.0
Persistent asthma	7.7	9.8	8.6	7.5

Source: Adapted from Wilper et al. (2009).

**TABLE 1.4 Comparison of Sexually Transmitted Infections Among U.S. General and Inmate Populations**

SEXUALLY TRANSMITTED INFECTIONS	GENERAL POPULATION (%) <sup>a</sup>	INMATE POPULATION (%) <sup>b</sup>
Chlamydia	0.4	2.4
Gonorrhea	0.1	1.0
Syphilis	0.005	2.6–4.3

<sup>a</sup>Centers for Disease Control (2009). <sup>b</sup>National Commission on Correctional Health Care (2002).

symptoms of a mental health problem (James & Glaze, 2006). This almost fivefold difference includes symptoms of mania, major depression, and psychotic disorders.

Borderline Personality Disorder (BPD) is also overrepresented in the inmate population. This mental health condition is characterized by poor impulse control, self-injury, and substance abuse with increased rates of diagnosis in the female population (National Institutes of Mental Health, n.d.). Studies vary widely; however, BPD rates in the general U.S. population are well below 5%, while estimates in the jail and prison population vary from 25% to 50% (Sansome & Sansome, 2009).

Correctional nurses need to understand mental illnesses to identify, refer, and support the patient's treatment. Nurses must also understand the implications of mental illness co-morbidity in managing other medical conditions. Vigilant monitoring for drug–drug interactions, preventing adverse reactions, and helping patients to tolerate and manage side effects are key aspects in nursing care of this population.

### Traumatic Brain Injury

Traumatic brain injury (TBI) and its effects are common in the inmate population. Although an estimated 2% of the general population has sustained a TBI with continuing disability (Langlois, Rutland-Brown, & Wald, 2006) a meta analysis of studies in the inmate population indicates a prevalence of over 60% (Shiroma, Ferguson, & Pickelsimer, 2010). This condition can be caused by a variety of brain traumas such as assault, falls, motor vehicle crashes, and military duty blasts (Centers for Disease Control, n.d.). TBI can lead to depression, anxiety, failed anger

**TABLE 1.5 Diagnosed Mental Conditions Among Inmates of State and Federal Prisons and Local Jails**

CONDITION	FEDERAL (%)	STATE (%)	JAIL (%)
Any diagnosed mental condition	14.8	25.5	25.0
History of medication for emotional or mental problems (among those diagnosed with a mental condition)	71.6	74.6	73.7
History of counseling for mental or emotional problems (among those diagnosed with a mental condition)	63.6	62.9	63.4

Source: Adapted from Wilper et al. (2009).

management control, and substance abuse. It can also predispose to seizure disorders, Alzheimer's, and Parkinson's diseases (Centers for Disease Control, n.d.). Correctional nurses must consider the impact of TBI aftermath on the functioning of the patient population. Case Example 1.2 provides opportunity to apply this information.

### **CASE EXAMPLE 1.2**

A 23-year-old male is being medically evaluated in a large urban jail, detained for disorderly conduct at a local bar. The inmate is belligerent and argumentative during the assessment. He is a large man, was a linebacker for his high school football team, and has a military history with deployment in Afghanistan. Based on his history, what primary and secondary conditions might the nurse assess for in this patient? ■■■

### **Posttraumatic Stress Disorder**

Another condition common in the inmate-patient population is posttraumatic stress disorder (PTSD). PTSD is an anxiety disorder that develops following a terrifying event or when an individual is frequently placed in dangerous or deadly situations (NIMH, 2011). Inmates enter the system with a variety of backgrounds leading to this condition, such as high levels of physical or sexual abuse and involvement in violent crime (Haugebrook, Zgoba, Maschi, Morgen, & Brown, 2010). Added to this is the trauma of incarceration with concerns over victimization, coercion, and assault. Military veterans make up 13% of state and 15% of federal prison populations and have high rates of PTSD from combat duty (Bureau of Justice, 2000). This condition is also common among female inmates due, in part, to the high level of child, domestic, and sexual abuse in their history (Binswanger et al., 2010). PTSD symptoms can affect the nurse-patient relationship. Triggers such as confinement, perceived coercion, and loud aggressive voice tones can cause PTSD victims to experience flashbacks and respond to perceived threat in nontypical fashion. An understanding of this condition and its prevalence in the patient population can aid the delivery of nursing care in the corrections setting.

### **Drug and Alcohol Involvement**

A staggering 84.8% of all U.S. inmates are substance involved, whether alcohol or illegal drug use (National Center on Addiction and Substance Abuse, 2010). Even those serving time for nonsubstance-related offenses have extremely high rates of dependence. More than half of those convicted of violent or property crime were alcohol involved at the time of the crime. In addition, substance involvement is frequently found to co-occur with mental health problems. Nearly one in four inmates have both a substance use disorder and a diagnosis of mental illness (National Center on Addiction and Substance Abuse, 2010).

Alcohol and drug withdrawal, therefore, is a major concern for correctional nurses working in corrections, particularly jails. Regardless of the setting for incarceration, inmates should be supported in the development of alternative coping

mechanisms because the evidence is clear that treating substance abuse reduces criminal recidivism.

### *From the Experts . . .*

“In the jail environment, nurses are challenged to treat individuals who are coming straight from the street and in many cases have had no health care prior to incarceration. They may have drug or alcohol addictions in addition to other chronic illnesses. In the prison population, the patients have had their chronic care needs identified and a treatment plan has already been established by the transferring jail. Jails would therefore be compared to an acute care setting and prisons would be considered more of a long-term care facility in regards to health care.”

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### **Tobacco Use**

Those entering the correction system are more likely to smoke tobacco. At least one-third of the prison population was smoking at the time of arrest, compared with one-quarter of the general population (The National Center on Addiction and Substance Abuse at Columbia University, 2010). Of particular note is the high rate of smoking among inmates with other substance issues. With the current trend for correctional facilities to become smoke-free, correctional nurses must look for ways to assist inmate-patients to cope with nicotine withdrawal.

### **Suicidality**

The inmate population, especially in jails, has greater potential for attempted and completed suicide than any other population (Hayes, 2010). Although the rate has dropped significantly since first tracked in 1980 (see Table 1.6), it is still a major concern that should be attended to by all correctional staff. Correctional nurses must consider suicide potential in all inmate contacts, but especially on intake, after sentencing or when at-risk for in threats while in custody such as rape, gang activity, or personal violence (Hanson, 2010).

**TABLE 1.6 Progress in U.S. Prison and Jail Suicide Rates  
1983–2006 (per 100,000)**

YEAR	U.S. POPULATION	JAIL	PRISON
1983	12.4	129	27
2006	11.3	36	17

Source: Condensed from Bureau of Justice Statistics (2011b), Centers for Disease Control, National Center for Health Statistics, National Vital Statistics System (2002).

## SUMMARY

Correctional nurses work in the challenging environment of jails, prisons, and juvenile detention facilities, sometimes with little resources, respect, or recognition. The correctional environment including the level of facility security, correctional officer, and administrative staff, and the inmate-patients, create a framework for the provision of nursing care. An understanding of the unique needs of the patient population and the specific restraints of the corrections environment allow nurses to be effective in maximizing health, decreasing illness, and reducing infection. Correctional nurses choose to use their knowledge and skills to care for a marginalized community of vulnerable patients who are often difficult to care for and care about. Many nurses find this a rich and fulfilling career choice.

## DISCUSSION QUESTIONS

1. What are some differences in jail and prison nursing based on information in this chapter?
2. Based on the context of correctional nursing, what would be key skills and characteristics for nurses in this environment?
3. What challenges to care delivery are found in the information in this chapter?
4. What are the similarities and differences between the population at your facility and the statistics describing the inmate population in this chapter?

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